WEST VIRGINIA CODE: §33-25A-8F

§33-25A-8f. Required coverage for reconstruction surgery following mastectomies.

(a) Any policy of insurance described in this article which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) All stages of reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Coverage shall be provided for a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring inpatient coverage where inpatient coverage is not medically necessary or where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the health benefit plan policy or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) A health benefit plan policy, and a health insurer providing health insurance coverage in connection with a health benefit plan policy, shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the issuer of the health benefit plan policy.

(c) A health benefit plan policy and a health insurer offering health insurance coverage in connection with a health benefit plan policy, may not:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

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(d) Nothing in this section shall be construed to prevent a health benefit plan policy or a health insurer offering health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) The provisions of this section shall be included under any policy, contract or plan delivered after July 1, 2002.

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